

Patient Symptom Checklist

Date: _____

Patient Name: _____

Patient ID: _____

Symptoms Checklist

Symptom	Yes	No
Fever	<input type="checkbox"/>	<input type="checkbox"/>
Cough	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>
Body Aches	<input type="checkbox"/>	<input type="checkbox"/>
Other Symptoms (please specify)	<input type="checkbox"/>	

Additional Comments

Signature of Patient: _____

Signature of Healthcare Provider: _____